STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245239	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Angels Health & Rehab Center	1500 East Third Avenue Hibbing, MN 55746

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to provide a requested second helping of food for 1 of 10 residents (R218) reviewed for dining. Findings include: R218's admission Minimum Data Set (MDS) dated [DATE], identified R218 had diagnoses which included heart disease, hypertension, and hyperlipidemia, no concerns with swallowing or oral/dental concerns. In addition, R218's MDS identified she was moderately cognitively intact. R218's care plan dated 3/21/25, identified R218 had a potential for alteration in nutrition due to leaving 25 % or more food uneaten at meals. Interventions included to monitor food and fluid intake, to offer fluids and snacks. On 6/9/25 at 3:39 p.m., R25 said there was sometimes not enough food during a meal. On 6/9/25 at 4:19 p.m., R218 said didn't always like the choices for food. On 6/11/25 at 11:00 a.m., in the [NAME] Woodlyn and [NAME] dining room R38 asked a nursing assistant (NA)-C for more and pointed to a black bowl. R38 was told I don't think we have any more of that. The NA-C did not go to the kitchen window and inquire if there was more watermelon. On 6/11/25 at 11:02 a.m., R38 verified she was told by staff there wasn't any more watermelon and said it was good. On 6/11/25 at 11:13 a.m., NA-C stated she didn't' really know if they were out of watermelon and stated residents get one serving each at a meal. On 6/11/25 at 11:40 a.m., licensed practical nurse (LPN)-C stated residents could have seconds as long as it was okay with their diet. On 6/11/25 at 12:08 p.m., dietary aide (DA)-A stated they did not run out of watermelon at brunch, added residents can have seconds and there was plenty of watermelon in the kitchen if staff would have asked. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 8:16 a.m., registered nurse (RN)-D stated residents should get seconds unless they have a dietary restriction. RN-D stated possibly the failure to see if there was more watermelon could have been related to staffing as staff are always rushing to the next thing they have to do. The facility policy titled Dining - Atmosphere undated, identified residents should be treated with dignity and respect, included it was extremely important to offer as many choices as possible when it came to meal time, including what to eat. In addition, the policy identified the dietary manager would routinely perform meal rounds to determine if the meals were attractive and nutritious and met the needs of the residents. The dietary manager would observe meals for preferences, portion sizes, and would report any concerns to the director of nursing or administrator.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure a resident did not self-administer medications (SAM) as assessed and according to the care plan for 2 of 2 residents (R40, R219) reviewed for SAM. Findings include: R40: R40's admission Minimum Data Set (MDS) dated [DATE], identified R40 had diagnoses which included chronic obstructive pulmonary disease (COPD [a group of lung disease that block airflow and make it difficult to breathe]), mild cognitive impairment, and supraventricular tachycardia (a faster than normal heart rate beginning above the heart's two lower chambers). In addition, R40 required partial to moderate assistance with activities of daily living. R40 had no rejections of care. R40's Order Summary Report current as of 6/12/25, identified R40 had orders for ipratropium-albuterol (used to treat COPD by opening the airways and reducing inflammation) inhalation solution 0.5-2.5 (3) milligrams per 3 milliliters one vial inhale orally three times a day dated 6/10/25. Instructions included to assess respiratory status, oxygen saturation, pulse and lung sounds after the treatment. R40's care plan dated 4/7/25, identified R40 was not able to administer her own medications. Interventions included, need to supervise medication per order. On 6/10/25 at 10:16 a.m., during a continuous observation, licensed practical nurse (LPN)-D set up a nebulizer treatment for R40 and said, all right I'll see you in a little bit and then left the room. -at 10:24 a.m., R40 was holding the nebulizer set up with the mouth piece in her mouth, the treatment sounded done, no staff returned to check on her. -10:28 a.m., R40 continued to hold the nebulizer set up with the mouth piece in her mouth, the treatment sounded done, no staff returned to check on her. -10:30 a.m., R40 held the nebulizer set up in her hand no longer in her mouth, no staff returned to check on her. -10:33 a.m., R40 had put the nebulizer set up with the mouth piece back into her mouth, no staff had returned to check on her. -10:37 a.m., no staff had returned to the room R40 continued to hold the nebulizer treatment with the mouth piece in her mouth. -10:45 a.m., no staff had returned to the room R40 continued to hold the nebulizer treatment with the mouth piece in her mouth. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10:50 a.m., 34 minutes after the nebulizer treatment had been started the nurse was alerted that R40 was still holding the nebulizer set up with the mouth piece in her mouth. LPN-D returned to the room, stopped the nebulizer treatment, took the nebulizer set up into the bathroom and rinsed the nebulizer set up. LPN-D did not listen to R40's lungs, check her heart rate or an oxygen saturation. On 6/9/25 at 2:37 p.m., family members (FM)-A, FM-B, and FM-C stated staff were not staying with R40 during her nebulizer treatments. They thought this was because there was not enough staff. On 6/10/25, at 2:10 p.m., LPN-D verified she left R40 until she was alerted that R40 was still holding the nebulizer treatment. LPN-D verified she did not return during the treatment to check on R40 and did not check, R40's heart rate, oxygen saturation, or listen to R40's lung sounds. LPN-D stated she was too busy and set up the treatment and went on to pass more medications and did not return until alerted. LPN-D reviewed R40's record and verified she was not assessed for self-administration of medications. On 6/12/25 at 8:31 a.m., registered nurse (RN)-D stated if a resident had been assessed to be okay to self-administer medications it would be okay to start a nebulizer treatment and come back in 15 minutes, check vital signs, listen to lung sounds, rinse the equipment. RN-D verified if a resident had not been assessed to self-administer medications, it would not have been okay to leave the resident alone during the nebulizer treatment. RN-D stated that portion of the hallway was split with another resident unit and the residents in the split hall don't get as much attention. On 6/12/25 at 11:15 a.m., FM-B handed over several pages of notes that included concerns about staffing (lack of). Note dated 6/3/25, second time in three days that I found neb hooked up, used, laying on the overbed table. I cleaned it. No one ever came in to check it in the three plus hours I was there. R219: R219's admission Record dated 6/12/25, identified an admission date of 6/9/25 with diagnoses of fracture of the left lower leg, hyperthyroidism, dislocation of the left ankle joint, orthopedic aftercare following surgical amputation (right great toe). R219's 48-hour care plan, undated, identified resident was alert and oriented, needs assistance with dressing, grooming, bathing, and an assist of one to transfer. The care plan didn't indicate R219 could self-administer medications. R219's provider orders dated 6/9/25, didn't identify an order for self-administration of medications. R219's medication administration record (MAR) for 6/12/25, identified the following medications were give to R219 this AM: -Amlodipine 5 mg one time per day -Aspirin 325 mg one time per day -Atenolol 50 mg one time per day (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Doxycycline 100 mg every 12 hours for 7 days -Gabapentin 300 mg three times per day -Levothyroxine 150 mcg one time pr day -Losartan 100 mg one time per day -Multiple vitamins, 1 tab daily -Spironolactone 25 mg one time per day R219's electronic medical record (EMR) didn't identify an assessment for self-administration of medication. During an observation and interview on 6/12/25 at 8:23 a.m., R219 was setting on the edge of his bed, the over-bed table was on the other side of the room with a white cup half full of medications. R219 stated the nurse left them there. On 6/12/25 2:50 p.m., during an interview the director of nursing (DON) stated a self-administration medication assessment needed to be completed prior to allowing a resident to self-administer medication. The Self-Administration of Medication by Resident policy dated 2/27/24, identified the purpose was To provide guidance to staff for assessing and accommodating resident's wish to self-administer their medications. The policy identified all residents would be asked on admission if they wanted to self-administer their medications. B. If the resident wishes to self-administer medications, they will be assessed for their ability to safely self-administer their medications. A Self-Administration of Medications (SAM) assessment will be completed and reviewed by the IDT (interdisciplinary team). This assessment will include: a. Cognitive status, b. Physical status, c. Which medications are appropriate to be self-administered, d. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Where the medications will be stored safely, e. How the nursing staff will monitor the medication's use, and f. How it will be documented.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** R28: R28's quarterly MDS assessment dated [DATE], indicated R28 was severely cognitively impaired with the diagnoses of Alzheimer's Disease, depression, psychotic disorder, and hallucinations. Section N. Medications indicated R28 received antipsychotic medications. R28's Care plan last revised 3/26/25, indicated R28 received antipsychotic medications and instructed AIMS assessments to be completed per policy. R28's Order Summary Active orders as of 6/18/25, contained the following orders: ---Seroquel 50 mg tablet at bedtime for Alzheimer and delusion disorder ---Seroquel 25 MG tablet give 1.5 tablet by mouth in the morning related to Alzheimer and delusional disorder. ---Observe closely for side effects of Antipsychotic medication including dry mouth, constipation, blurred vision, disorientation or confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea or vomiting, lethargy, drooling, EPS symptoms (tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue) R28's electronic and paper medical record lacked evidence to show Aims [assessment for EPS (antipsychotic drug side effects)] and orthostatic blood pressure [drop in blood pressure when going to an upright position from laying or sitting] monitoring had occurred as ordered. During an interview on 6/12/25 at 11:41 a.m., registered nurse (RN-A) stated the facility completed AIMS assessments in conjunction with quarterly assessments. AIMS assessments should be completed because it assessed for signs of tardive dyskinesia. Orthostatic blood pressures were done on residents receiving antipsychotic medication for safety. RN-A reviewed R28's record and confirmed R28 had missing AIMS assessments and orthostatic blood pressures were not being done on R28. During an interview on 6/12/25 at 2:04 p.m., the director of nursing (DON) stated they would expect orthostatic and AIMS assessments to be completed per policy on residents who were receiving psychotropic medications. In a follow-up e-mail on 6/12/25 at 3:07 p.m., the DON reported no AIMS assessments had been completed on R28 since 10/1/24. The policy Psychotropic Medications dated 5/21/25, instructed AIMS or DISCUS assessments were to be completed at least every six months on residents prescribed antipsychotics. The policy included the provider was to identify if a resident required monthly orthostatic blood pressure monitoring. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and document review, the facility failed to ensure as-needed (PRN) psychotropic (medications which affect the mind, emotions, and behavior) medications had an end date for 2 of 5 residents (R32, R21), and failed to ensure residents receiving psychotropic medications were assessed for extrapyramidal movements (involuntary, uncontrolled muscle movements) and orthostatic blood pressure for 2 of 5 residents (R11, R28) reviewed for unnecessary medications. Findings include: R32: R32's significant change Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and diagnoses of Parkinson's disease with dyskinesia, and dementia. R32 was enrolled in hospice services. R32's care plan dated 3/24/25, identified a mood problem related to anxiety and included interventions to administer medications as ordered. Monitor and document side effects and effectiveness. R32's electronic medical record (EMR) contained an order dated 5/16/25, for lorazepam (a benzodiazepine used for anxiety) 0.5 milligrams (mg) PRN every four hours for anxiety and restlessness. The order didn't contain a stop date. During an interview on 6/12/25 at 8:55 a.m., RN-D confirmed R32's lorazepam order didn't have a stop date, she added she had faxed about it last week. During an interview on 6/12/25 at 9:53 a.m., the director of nursing (DON) confirmed there wasn't a stop date for the lorazepam, but the hospice provider/rounding provider was on vacation. R21: R21's quarterly MDS dated [DATE], identified R21 as moderately cognitively impaired, with diagnoses that included severe protein-calorie malnutrition, anxiety, adjustment disorder, depression, radiculopathy of the lumbar region, hypertension, and a stage IV pressure ulcer in the sacral region. R21's order summary dated 6/11/25, indicated an order for clonazepam (psychotropic medication used to treat anxiety) 0.5 milligram (mg) tablet to be given by mouth every 4 hours as needed (PRN) for anxiety. The order started on 6/10/25, and did not have an end date. During interview on 6/12/25 at 7:45 a.m., registered nurse manager (RN)-E stated R21's order for PRN clonazepam was discontinued on 6/9/25. RN-E checked R21's medical record and verified the order for PRN clonazepam was active in resident's chart. RN-E stated the order needed to have an end date due to being a PRN antipsychotic medication. During interview on 6/12/25 at 3:20 p.m., director of nursing (DON) stated expectation for PRN psychotropic medications to have an end date. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Psychotropic Medications policy issued on 5/21/25, indicated PRN psychotropic medications ordered will be limited to 14 days. The prescribing practitioner will evaluate and document the medications necessity, benefits, and improvement (expressions, indications of distress). If the physician deems it appropriate to extend beyond the 14-day limit, supporting rationale must be documented. R11: R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 as cognitively intact with diagnoses that included congestive heart failure, type 2 diabetes, chronic kidney disease, chronic pain, severe depression with psychotic symptoms, atrial fibrillation, anxiety, anemia, post-traumatic stress disorder, hypothyroidism, and hypertension. MDS indicated R11 received an anxiolytic (treats anxiety) medication. R11's care plan last revised on 6/9/25, identified resident taking antipsychotic medication with an intervention of completing an abnormal involuntary movement scale (AIMS) or dyskenesia identification system: condensed user scale (DISCUS) as indicated. Review of R11's medical chart revealed no AIMS or DISCUS had been completed. R11's order summary report dated 6/12/25, indicated an order for buspirone 1 milligram (mg) tablet and instructed staff to give 2.5mg by mouth as needed (PRN) for anxiety. The order for buspirone started on 4/22/25 and did not have an end date. R11's order summary also indicated an order for risperidone 0.5mg tablet to be given once a day at bedtime for depression. The order for risperidone started on 5/15/25 and did not have an end date. R11's medication administration record (MAR) reviewed 4/1/25 through 6/11/25, identified no PRN buspirone was given, however the order remained active. During interview on 6/12/25 at 3:20 p.m., director of nursing (DON) stated expectation for PRN psychotropic medications to have an end date. DON also expected residents taking antipsychotic medication have an assessment such as the abnormal involuntary movement scale (AIMS) done to monitor for side effects like tardive dyskinesia (neurological condition with involuntary and repetitive muscle movements). Psychotropic Medications policy issued on 5/21/25, indicated PRN psychotropic medications ordered will be limited to 14 days. The prescribing practitioner will evaluate and document the medications necessity, benefits, and improvement (expressions, indications of distress). If the physician deems it appropriate to extend beyond the 14-day limit, supporting rationale must be documented. Policy also indicated Complete a DISCUS or AIMS assessment on any resident prescribed an antipsychotic at least every 6 months. Any changes will be reported to the physician.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure timely reveiw and revision of the care plan occured for 2of 2 residents (R41, R11) reviewed for care planning. Findings include: R41: R41's quarterly Minimum Data Set (MDS) dated [DATE], indicated R41 was moderately cognitively impaired with the diagnoses of stroke, dysphagia, generalized muscle weakness, and epilepsy. MDS Section GG indicated R41 was dependent for activities of daily living and transfers. R41's Care plan last revised 6/3/25, identified R41 as a risk for falls on 3/19/25. The care plan lacked evidence to show R41's fall prevention interventions had been revised before or after R41's fall on 6/7/25. A nursing note entry made on 6/7/25, identified R41 had been placed in their recliner and then was later found on the floor. Post assessment revealed R41 had not sustained a significant injury. A nursing note entry made on 6/10/25, indicated an interdisciplinary disciplinary review had been completed for R41's fall on 6/7/25, and the root cause was identified. R41 had gotten ahold of the remote and placed recliner in the upright position and slid out. Intervention identified was to unplug the chair. During an interview on 6/12/25 at 11:58 a.m., registered nurse (RN-A) reviewed R41's chart and confirmed R41 had fallen out of their recliner on 6/7/25. R41 had gotten ahold of the chair remote buttons which led to a fall to the floor. RN-A confirmed R41's care plan had not been updated with new fall prevention interventions after post fall analysis was completed. RN-A stated normally the care plan got updated with changes in care for residents, but R41's care plan had not been updated. During an interview on 6/12/25 at 2:00 p.m., the director of nursing (DON) stated falls get reviewed at the manager level and at an interdisciplinary team level. R41's care plan should have been updated with fall interventions after R41's fall was reviewed. The facility policy Person Centered Care Planning dated 12/18/23, identified resident's immediate health and safety concerns to prevent decline or injury such as fall risk should be addressed in the care plan. The policy also identified care plans were to be updated on an ongoing basis as needed based on changes that occurred between care conferences. R11: R11's quarterly MDS dated [DATE], identified R11 as cognitively intact with diagnoses that included congestive heart failure, type 2 diabetes, chronic kidney disease, chronic pain, severe depression with psychotic symptoms, atrial fibrillation, anxiety, anemia, post-traumatic stress disorder, hypothyroidism, and hypertension. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's order summary report dated 6/12/25, indicated an order for risperidone (antipsychotic) 0.5 milligram (mg) tablet to be given once a day at bedtime for depression started on 5/15/25, an order for citalopram hydrobromide (antidepressant) 20mg to be given in the morning for depression started on 4/1/25, an order for warfain sodium (anticoagulant) 1mg tablet to be given in the evening every Tuesday, Thursday, Saturday, and Sunday for atrial fibrillation started on 5/20/25, and an order for 1.5 tablets of warfarin sodium 1mg to be given in the evening every Monday, Wednesday, and Friday for atrial fibrillation started on 5/21/25. R11's care plan last revised on 6/9/25, identified focus areas of I use antidepressant medication (Specify medications), I am on anticoagulant therapy (Specify medication), and I have a diabetic ulcer of the (specify location). During interview on 6/12/25 at 3:20 p.m., director of nursing (DON) stated expectation for care plans to be complete. DON stated importance of completing care plans as the plans contained information needed to effectively care for a resident. Person Centered Care Planning policy last revised 12/18/23, identified the care plan describing the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.' Policy indicated the resident's care plan is reviewed every 90 days or more frequently if necessary with a significant change. Care plans are updated on an ongoing basis as needed based on changes that occur between care conferences.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure activities of daily living (ADLs) were completed for 4 of 5 residents (R1, R64, R16, R9). Findings include: R1: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had diagnoses which included dementia, anxiety, heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), insomnia, and macular degeneration (an eye disease that causes vision loss). In addition, R1's MDS identified she required substantial to maximum assistance with ADLs, was frequently incontinent of bowel and bladder, and was at risk for pressure ulcers. According to R1's MDS she had no rejections of care. R1's care plan dated 3/9/25, identified R1 had an ADL self-care performance deficit related to dementia. Interventions included I like my nails trimmed and cleaned during my bath, preferred bathing twice a week in the afternoon. R1's care plan dated 4/22/25, identified R1 was at risk for bladder incontinence and required staff assistance. Interventions included to offer toileting four times a day - upon rising, after brunch, before supper and before bed. R1's bath report for May and June 2025, did not identify if nail care was offered, refused or completed. On 6/9/25 at 6:12 p.m., R1's fingernails were noted to be long, polished and had a dark brown caked substance under them. On 6/11/25 during a continuous observation that began at 8:16 a.m., R1 was observed seated in the dining room eating hot cereal, she had a nutritional drink, was dressed for the day, and had a newspaper on the table. -8:32 a.m., R1 remains at the table said breakfast was okay but not her favorite, would have rather had peanut butter toast. -8:51 a.m., R1 remains at the table in the dining room, no staff interactions -9:11 a.m., R1 remains at the table in the dining room, no staff interactions -9:30 a.m., table cleared R1 ate 100 % of breakfast -9:56 a.m., R1 remains at the table in the dining room, no staff interactions, no position change, no off-loading -10:37 a.m., R1 has remained seated at the table in the dining room, no repositioning, no position change, no offer of bathroom, no staff interactions (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Angels Health & Rehab Center	1500 East Third Avenue Hibbing, MN 55746

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11:16 a.m., R1 has remained in the dining room at the same table no position change, no offer of bathroom, no staff interactions (now 3 hours seated in the same chair in the same spot) -11:22 a.m., R1 has been served her brunch meal -11:40 a.m., asked licensed practical nurse (LPN)-C about R1 sitting in the same spot since breakfast. LPN-C stated it was too long for anyone to sit in one position and she would find someone to do a position change. -12:01 p.m., LPN-C asked two different nursing assistants for help to reposition R1 and both stated they were busy and unable to assist -12:19 p.m., activity staff were going to bring R1 directly to exercise class with out a bathroom break -12:21 p.m., R1 was brought to her room by nursing assistants (NA)-E and NA-F. Both donned isolation gowns, gloves, placed transfer belt on R1 and transferred her to the toilet. NA-E stated R1 was not always continent and said R1's brief was wet but not soaked. -12:36 p.m., R1 was was transferred back to the wheel chair, brought to her bed, transferred to her bed for skin check. Skin was slightly red with no open areas. R1 was transferred back to her wheel chair. -12:43 p.m., NA-E looked at R1's nails and said oh ya, her nails look dirty, NA-E stated she was going to try to soak her hands and clean her nails later. On 6/12/25 at 12:30 p.m., R1 was brought from the dining room directly to the exercise program in [NAME] Park. No stop was made in R1's room for toileting. On 6/11/25 at 12:26 p.m., NA-E stated R1 was not on a toileting schedule. NA-E and NA-F said they were taking care of 30 residents. During the chair to toilet transfer and chair to bed transfer NA-F said can we do this later, said they had no time to wait around. On 6/11/25 at 2:13 p.m., LPN-C stated it had been too long for R1 to sit without a position change. Said she had never seen R1 move or change her position once she was in her wheel chair. LPN-C said they did not have enough staff today. Verified the NAs were taking care of 30 residents, she was passing medications for 25 residents, they were expecting two new residents and one resident was coming back to the facility. LPN-C stated she worked days and would not pick up night shifts because she didn't want to be the only licensed staff in the building. On 6/12/25 at 7:55 a.m., registered nurse (RN)-E verified resident nails should have been looked at daily when they were being dressed. RN-E sated there was not enough staff on the unit, staff are running and triaging their work. RN-E verified sitting for over three hours in one place is too long and she would expect a resident to be offered every two hour toileting. RN-E stated R1 was on a toileting schedule and not being left sitting in one spot for over three hours might be related to staffing (lack of). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/25 at 12:40 p.m., NA-D stated R1 was supposed to be toileted after brunch, but doesn't always happen because sometimes working alone. On 6/12/25 at 3:00 p.m. the director of nursing (DON) verified R1 sat too long without being offered a position change or toileting. The DON stated nail care should have been done on bath days. The policy Nails care of (finger and toe) dated 9/2006, identified the purpose of nail care was to provide cleanliness, prevent the spread of infection, for comfort, and to prevent skin problems. The policy did not address the frequency of nail care. The policy Urinary Incontinence Program dated 4/6/15, identified the purpose as follows: Each resident who is incontinent will be identified, assessed, and provided appropriate care and services to achieve or maintain their greatest level of continence. Each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible. R64: R64's significant change MDS dated [DATE], identified R64 had diagnoses which included dysphagia (difficulty swallowing foods or liquids arising from the throat or esophagus) following cerebral infarction, vascular Parkinsonism (a form of parkinson's caused by damage to blood vessels in the brain, often due to stroke or other vascular issues), rheumatoid arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet), anxiety, and adult failure to thrive. In addition, R64's MDS identified she was dependent on staff for ADLs, was always incontinent of bowel, was at risk for pressure ulcers, and had no rejections of care. A complaint was received on 3/24/25, with concerns R64 was left soiled and wet on 3/19/25, 3/20/25, from end of day shift through evening and night shift until day shift on the following day. During an interview on 6/9/25 at 6:17 p.m., nursing assistant (NA)- O stated she was working in [NAME] Woodland /[NAME] and was taking care of 28 residents. NA-O was working with two other NAs who would be leaving at 6:30 p.m., so after dinner they got almost everyone on the unit to bed because the other two would be leaving soon. During an interview on 6/10/25 at 1:44 p.m., NA-J stated they had put their initials on R64's brief at the end of their shift for three days. They stated their initials were on the brief when they returned for their next day shift and said the brief had not been changed by evenings or nights. R64 had been a resident on the [NAME] Woodland / [NAME] unit. NA-J stated they reported this to two different nurses, the nurse manager, and the director of nursing (DON). NA-J stated the past weekend there were only two NAs working, could not complete check and changes and could not get a shower done for R40. NA-J stated feels like every day it's short staffed, can't get residents up by 10:30 a.m., can't get daily weights done, no time for one to ones with residents, and you do what you can. There should be three NAs for [NAME] Woodland / [NAME], but there isn't always. During an interview on 6/12/25 at 8:20 a.m., RN-D stated she had no knowledge of any NA coming to her with concerns that R64's brief was not being changed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/25 at 9:01 a.m., NA-I stated he recalled helping a co-worker with a brief change for R64 and saw twice that the brief had NA-J's initials on it from the day before. NA-I stated he recalled NA-J had reported the concern to management. NA-I stated could not recall any education on check and changes after the reported incident. NA-I stated when they were the only NA couldn't get checks and changes done timely. NA-I stated evening shift was the shift were there typically wasn't enough help, often leaving the unit(s) short from 6:30 p.m.-10:30 p.m., when trying to get residents ready for bed. Said the facility can only mandate NAs for four hours when there is a call in so then work short for the rest of the shift. During an interview on 6/12/25 at 12:40 p.m., NA-D stated she recalled changing R64 with another NA and saw the NA's initials from the day before on the resident's brief. NA-D said R64's brief would often be soaked in the morning. On 6/12/25 at 2:09 p.m., the DON brought in a nursing note for R64 dated 3/21/25, 11:13 a.m., Peri area/buttocks checked today for concerns. ADON and NAR present. No redness, irritation or open areas noted to groin/vaginal or buttock areas. Coccyx has a dry/flaky area on it. Calmoseptine applied to coccyx. Catheter patent and draining amber colored urine. The ADON was not available for interview, no longer worked at the facility. The DON stated nothing was wrong and they did not complete an investigation. She recalled she was not working on that day. The DON stated it would be her expectation that R64 would have been checked and changed every two hours and repositioned to prevent skin breakdown. During an interview on 6/12/25 at 2:50 p.m., the DON said the NAs should know who is on a toileting program by looking at the kardex. In addition, the toileting program should also be on the care sheets. R9 R9's admission Minimum Data Set (MDS) dated [DATE], indicated cognitive patterns weren't assessed. R9's MDS included diagnoses of pneumonitis due to inhalation of food and vomit, acute cystitis, orthopedic aftercare, chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia, heart failure, and dementia. R9 had limited range of motion in both upper extremities, one lower extremity, needed assistance with ADLs, and had an indwelling catheter. R9's Order Summary Report dated 6/12/25, didn't contain a line item for indwelling catheter care. R9's care plan dated 5/22/25, didn't address ADL status, catheter care, medications, or treatments. During an interview on 6/9/25 at 6:44 p.m., R9 stated she didn't get washed up in the morning and would like the opportunity to wash her face and stuff. During an interview on 6/11/25 at 10:46 a.m., R9 was up in her wheelchair with the over-the-bed table in front of her. R9 stated the aids helped her up to her chair and got her some breakfast, but she didn't get washed up. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/25 at 1:19 p.m., an anonymous staff (AS)-G stated they would normally get their work done on the [NAME] Park unit, but not on the [NAME] unit. AS-G reported some of the things they couldn't get done were restorative care, charting, and things like that but that they could get showers and ADLs done most of the time. AS-G stated they were constantly on their feet, keeping up with call lights, running around and doing the best they could. For R9, AS-G stated they got her up right before brunch and they were not able to do her cares. During an interview on 6/11/25 at 1:37 p.m., AS-H stated they were able to get their work done but not to the ability they would like; they have so many call lights and the staffing was usually only two staff on this unit. AS-H stated there were about 10 two-person transfers in this unit so when they went into a room to help a resident, the floor was left empty. AS-H stated they could get everyone up and dressed but would like to be able to give a nice bed bath and spend more than 10 minutes with them and get to really get to know them. For R9 today, she got up later than usual, and AS-B wasn't able to do any washing up for her today, just able to get her dressed, empty her catheter and transfer her to a chair. AS-B confirmed this meant catheter care wasn't done. During an interview on 6/12/25 at 8:43 a.m., RN-D stated care plans were done 14 days after admit and R9's assessment reference date (ARD) was 5/22. RN-D didn't comment about R9's incomplete care plan, but did say care plans were important, so aids and nurses knew how to care for the resident. RN-D stated they should be doing catheter cares at least twice a day, anytime incontinent, and this included peri care and cleaning the tubing where it exited the body. This was important to prevent infection. During an interview on 6/12/25 at 9:34 a.m., the director of nursing (DON) stated it was their protocol to have a comprehensive care plan in place 14 days after the ARD, or 21 days after admission. The DON stated catheter care was part of AM and PM cares, and the risk of not doing it could be a urinary tract infection (UTI). A policy, Catheter Care dated 9/11/23, identified the purpose was to maintain catheter patency, prevent infection and ensure dignity and provided instructions for care, but didn't address frequency. The daily care procedure was described: Gather all equipment: basin with warm water and soap, towel and washcloth, disposable gloves and other personal protective equipment as necessary, collection device, and antiseptic ointment as ordered, if applicable. Wash your hands thoroughly before and after performing the procedure; immediately after your hands encounter blood, body fluids, or tissues, and/or after handling soiled laundry or linen. Gloves must be worn while giving catheter care. Gowns will only be necessary if soiling of your clothing with urine, feces, or blood is likely. Masks/eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. Keep soiled linen from touching your clothing. Knock before entering the room, introduce yourself, and inform the resident of the procedure. Place the equipment and supplies on the bedside stand or over the bedside table and arrange the supplies so that they can be easily reached. Position resident in semi-Fowlers position, if tolerated. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put on gloves. For female, separate labia. For male, push back foreskin. Wash perineum with soap and water, taking care to wash from front to back; using one area of washcloth per washing stroke; rinse and pat dry using same procedure. Cleanse area of catheter insertion site using soap and water being careful not to pull on catheter or advance further into urethra. Hold catheter at insertion site to anchor, wash downward from meatus four inches, changing washcloth with each stroke; rinse and pat dry using same procedure. Towel dry perineal area and on the male return the foreskin to normal position. Secure catheter by utilizing a leg band. Position resident for comfort and remove and clean used equipment. Make sure catheter tubing and drainage bag are kept off the floor. Place it in a basin if it cannot hung from the bed. Cover drainage bag with a cloth/vinyl bag to protect the dignity of the resident. Remove and discard gloves. Wash hands. R16 R16's quarterly MDS dated [DATE], identified intact cognition and diagnoses of hemiplegia and hemiparesis affecting left side, cerebral infarct (stroke), dysphagia (difficulty swallowing), traumatic subarachnoid hemorrhage (brain bleed), and post-traumatic seizures. R16 needed maximum assistance with personal hygiene and dressing upper and lower body, and was dependent for transfers. R16's provider orders dated 3/27/25, identified vital signs, weight, and skin checks were to be done weekly on bath/shower day every Monday. R16's care plan dated 3/24/25, identified a self-care deficit with interventions to provide an assist of one for oral and personal hygiene, and to shave face upon request. R16's progress notes didn't contain an entry for resident refusal of bath/shower, and didn't contain a skin check for Monday 6/9/25. During an observation and interview on 6/9/25 at 2:28 p.m., R16 was noted to have chin hair approximately ¼ to 1/3 inch long. R16 stated they were going to shave her when she had her bath, but they were short staffed and she didn't get her bath and that was when they usually shaved her. During an observation on 6/10/25 at 8:53 a.m., R16 was noted to have chin hairs as she did yesterday. During an observation on 6/11/25 at 8:32 a.m., R16 was in bed eating toast and was noted to have chin hairs still present. During an interview on 6/12/25 at 1:04 p.m., LPN-E stated she had noticed the facial hair on R16 and had asked NA-I to shave her on maybe Tuesday, but it must not have gotten done. During an interview on 6/12/25 at 1:26 p.m., the DON stated R16 often refused different things, and they had been adequately staffed on her bath day. The DON would expect a note with refusals and if a resident refuses often, she would expect it to be in their care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to track bowel movements and provide related interventions for 2 of 4 residents (R9, R32), failed to monitor a resident's oxygen saturation levels per provider order for 1 of 4 residents (R9), and failed to complete ordered skin checks for a resident with a skin condition for 1 of 4 residents (R22) reviewed for quality of care. Findings include: R9: R9's admission Minimum Data Set (MDS) dated [DATE], indicated cognitive patterns weren't assessed. R9's MDS included diagnoses of pneumonitis due to inhalation of food and vomit, acute cystitis, orthopedic aftercare, chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia, heart failure, and dementia. R9 had limited range of motion in both upper extremities, one lower extremity, needed assistance with ADLs, and had an indwelling catheter. R9's care plan dated 5/22/25, didn't address oxygen or bowels. R9's provider orders identified the following: -4/13/25, an order for docusate sodium 100 mg by mouth two times per day. -5/6/25 sennosides-docusate sodium 8.6/50 mg by mouth two times per day 1-2 tabs two times per day while on oral narcotics to prevent or treat constipation. -5/8/25 Hydrocodone 5/325 mg every four hours as needed for pain. -5/22/25, to take daily oxygen saturation, wean oxygen as tolerated to keep saturation levels greater than 90% one-time per day. R9's progress notes for May 2025 didn't reveal any notes regarding R9 not having had a bowel movement for more than 48 hours nor was there an assessment of R9's bowel status. R9's progress notes did identify an entry on 5/21/25, noting resident had a dry cough, but oxygen saturation was 94% on 2 liters per minute (LPM). R9's Weights and Vitals Summary for May and June 2025 had the following entries: -5/16/25 90% on room air -5/19/25 91% on room air -5/20/25 90% on room air -5/24/25 93% on oxygen (LPM not given) -6/1/25 95% on oxygen (LPM not given) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6/6/25 96% on oxygen (LPM not given) -6/7/25 94% on room air Review of R9's medication administration record (MAR) and treatment administration records (TAR) for May and June 2025, revealed no line items for oxygen administration indicating if oxygen was used, and if so at what liter flow. R9's electronic medical record (EMR) identified the following dates in May 2025 where no bowel movements were recorded: 5/22, 5/23, 5/24, 5/25, and 5/28, 5/29, 5/30. During an interview on 6/9/25 at 6:48 p.m., R9 stated she had trouble with constipation all the time, if she could get prune juice with her stool softener, she would be fine, but they didn't do that. R32: R32's significant change MDS dated [DATE], identified severely impaired cognition and diagnoses including Parkinson's disease with dyskinesia (a movement disorder), and dementia. R32 was non-ambulatory, dependent for mobility, toileting and toilet hygiene. R32's care plan dated 3/25/25, identified an activities of daily living (ADL) self-care deficit and needed an assist of two to check/change incontinent product and offer the bathroom every two hours. Check every two to three hours at night. Frequently incontinent of bladder, continent of bowel. Constipation was not addressed. R32's provider orders: -3/18/25 prune juice one time a day for constipation -4/16/25 monitor BMs, if no BM in 48 hours give PRN MiraLAX one time a day for constipation. -4/16/25 MiraLAX 17 grams give one scoop as needed for constipation if no BM in 48 hours - please give!! Review of R9's EMR revealed the following: -bowel movements for May and June 2025 were recorded on the following dates: 5/20, 5/25, 6/5 and 6/8. -MAR and TAR for May and June 2025 didn't have MiraLAX signed out. -MAR and TAR had the order monitor BMs, if no BM in 48 hours give PRN MiraLAX one time a day was signed off every day of June, and all but one day of May. During an interview on 6/9/25 at 2:16 p.m., family member (FM)-H stated R32 had lots of trouble with constipation and explained he was on many medications that made this worse, she had talked with staff about this before and he had an order for MiraLAX now. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/25 at 8:43 a.m., registered nurse (RN)-D stated R9's order for oxygen might be under the standing orders because she had gotten sick and needed it and then went to the hospital. RN-D confirmed the current order was for daily oxygen saturation levels and to wean to keep 90% or better and stated they usually started at one to two liters per minute (LPM), get a baseline from what the hospital had had them on and then work on weaning the oxygen. It would be important to know her levels to see if she was tolerating being weaned. BM protocol 3 days no BM they start with prune juice, then go to something a little heavier like MiraLAX, they can do MOM, supp, enema depending on how long they have gone without a BM. The NAs chart the BMs. On PCC there is a clinical dashboard where they can see if there is someone who has gone more than 48-72 hours. The expectation would be there is a one-time standing order for a prn or a nursing order. During an interview on 6/12/25 at 9:34 a.m., the director of nursing (DON) explained the standing orders for oxygen PRN one to four LPM would cover the PRN oxygen R9 was using because R9's provider had signed an order for house standing orders including the PRN oxygen. The DON confirmed the house standing orders for oxygen weren't on R9's orders, and a liter flow wouldn't be recorded on the MAR, but a copy of them was on every medication cart. The DON stated her expectation would be that bowel movements were recorded by the NAs and the nurses and would expect to see an intervention for the missed bowel movements. A document, House Standing Orders dated 10/10/23, identified under directions item number 2, the standing house orders are documented through the electronic health record. In addition: Bowel Regulation/Protocol - Constipation 1. If the resident hasn't had a BM in the last 24 hours may receive dietary interventions such as prune juice or fiber. 2. Milk of magnesia (or equivalent) 30 mL by mouth daily as needed for constipation. 3. Dulcolax suppository 1 supp rectally daily as needed for constipation. Fleets enema rectally daily as needed for constipation. If no results within 2 hours after the enema, notify the MD/NP. 4. MiraLAX 17 grams daily as needed for constipation. If PRN bowel meds are used more than twice in one week, assess for routine bowel regimen need. 5. Senna two tablets daily at bedtime as needed for three days. Cough/Respiratory Symptoms - Oxygen (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. One to four LPM via nasal cannula or mask as needed for respiratory distress, acute dyspnea, hypoxia (to bring saturations above 88%) or acute angina (no more than two LPM for residents with COPD. Notify MD. R22: R22's quarterly MDS dated [DATE], identified moderately impaired cognition and a diagnosis of livedoid vasculitis (a rare, chronic disorder causing painful, recurrent ulcers primarily on the lower extremities, which heal to an atrophic, porcelain-white scar). R22's care plan dated 3/25/25, identified she needed an assist of one for bathing/showering, and had potential for skin impairment of the buttocks/peri area related to incontinence. R22's care plan had interventions to keep fingernails short, inspect skin weekly, keep skin clean and dry, provide peri care with incontinent episodes and observe skin daily with cares. An order dated 4/1/25, identified skin charting every evening shift on Fridays, chart on the Nursing Advanced Skin Check in the assessments tab and complete. R22's EMR didn't contain any skin assessments. During an interview on 6/11/25 at 4:06 p.m., RN-D stated the cart nurse was responsible for the skin checks with the resident bath, all residents get them weekly on their bath day. The facility's expectation was that it was done every week. RN-D stated she did know R22 refuses baths. A policy, Skin Integrity dated 5/21/25, identified the purpose was to provide guidance to nursing staff on identifying, evaluating, monitoring, and preventing resident skin integrity issues. Braden, tissue tolerance, and skin assessments will be completed in the electronic health record (EHR). Further, under monitoring, the policy indicated a licensed nurse would complete a skin check weekly and document in the EHR. The licensed nurse will observe changes in skin integrity and treatments, will notify the nurse manager, wound nurse, or designee with any changes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure there were sufficient numbers of staff to ensure all resident cares including activities of daily living (ADLs), toileting program/schedules, and check and changes, were completed timely for 4 of 5 residents (R1, R64, R16, R9), residents food requests were acted upon for 1 of 10 residents (R218), and residents were properly supervised during medication administration for 1 of 2 residents (R40). This had the potential to affect all residents residing in the facility. Findings include: Staff and Family Interviews/Observation: During an interview on 6/9/25 at 2:37 p.m., family members (FM)-A, B, C, stated on 5/28/25, when R40 returned from the hospital at 2:00 p.m., no one checked on R40. At 9:00 p.m., (seven hours later)FM-A went to the nurses station to get help. FM-A stated no one could figure out how to connect the alarm pad that would turn on the call light if R40 got up without help. FM-A said she didn't feel safe leaving so stayed all night. FM-A stated at 3:00 a.m., (six hours later) staff came in and then no more checks were done. FM-A met with leadership that morning to discuss her concerns. FM-A, B, C stated they would come to visit and R40 would still be in her pajamas from the day before (said once it was three days in the same pajamas). On 6/9/25 at 6:53 p.m., on [NAME] Woodland /[NAME] there were no staff at the desk or visible in the hallways, R17 was eating ice cream and had a cup of coffee, and was asking where her husband was. Nursing assistant (NA)-O said she had to rush to get everything done because she was alone on the unit. During an interview on 6/12/25 at 8:31 a.m., registered nurse (RN)-D stated staffing in that hall (Wells Woodland) didn't get as much attention. Stated it could be staffing related if nursing was not offering toileting every two to three hours. During an interview on 6/12/25 at 9:55 a.m., scheduler (S)-G said staffing calls would come to the nurse, the nursing unit, or the staffing office. They would then be circled on the schedules and messages would go out via bright arrow (two different groups licensed and NAs). If no response then text messages to individuals, if no response, then mandate staff (verified have run out of staff to mandate). If unable to fill the call in then work short, nursing and the scheduler would decide how to divide up the staff or if it was possible to pull staff from another unit. During an interview on 6/12/25 at 11:45 a.m., anonymous staff (AS)-G stated they did rounds as able. AS-G and their partner were caring for about 30 residents. AS-G stated when they would come out of rooms there were often lots of call lights on, sometimes as many as four. AS-G stated they struggle to get the work done when there were only two NAs. AS-G stated they had a week where they cried after work and felt like quitting because of short staffing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/12/25 at 12:40 p.m., NA-D stated she recalled a shift on 5/29/25, said she was taking care of 30 residents by herself, said that had happened more than that time. We get behind, can't do check and changes timely, can't get baths done, and had been told by nurses to let it go. She had reported not being able to get work done to the nurse manager and the director of nursing (DON). During an observation on 6/12/25 at 11:15 a.m., FM-B handed several hand written notes regarding concerns with care and staffing (which had previously been brought to the facility's attention): -R40 weak, doesn't use call light, needs frequent monitoring -R40 not independent in ADLs, doesn't remember to get dressed without someone physically being there. Had not been dressed several days when family arrived to visit. -Not ready three times for appointments (had called or discussed the need to be ready at a specific time) when family arrived incontinent, in pajamas, hair not combed. -needs a toileting schedule and needs assistance with incontinence products -no assessment completed upon return from the hospital on 5/28/25, (after return around lunch time, RN saw her asked about skin, vital signs were completed, NA saw her said hello, no offer to toilet, meal tray delivered, nebulizer treatment). Around 8:30 p.m., FM-A went to nurses station, R40 was begging to go to bed (no call light in the room), at the station two staff, one identified self as NA said, we should've at least checked on her. I'm sorry. This is the first time I've sat down, it's been so busy. FM-A had taken R40 to the bathroom several times and had gotten her ready for bed. None of the staff knew how to connect the pad that would turn on the call light if R40 got up without calling for help. FM-A decided to stay because no one had checked on R40 for an entire shift. I decided I didn't dare leave so I sat in Mom's recliner all night. No one checked on R40 until 12:38 a.m., (three and one half hours). FM-A had taken R40 to the bathroom twice during that time period. At 4:30 a.m., a staff came in said, glad to have you back, but did not offer to toilet or check incontinence product. FM-A requested a meeting, at 10:00 a.m., a meeting was held with management staff. Assurances were made for cares. Prior to the meeting none of the day staff had come in to check on R40. By 1:00 p.m., no one had assisted R40 with morning cares (toileting, oral care, dressing, hair brushing). Went to the nurse manager to ask why no cares. About 10 minutes later a NA arrived, apologized, said they were short staffed with only two NAs for 30 residents. -6/5/25, no brief, chair soaked, bed wet -6/6/25, not dressed when arrived at 10:00 a.m. -6/7/25, in pajamas all day -6/8/25, same pajamas, no shower, was told if there was time they might do it, there for over three hours, no checks, no toileting, no shower Activities of Daily Living: see also F677 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R1: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had diagnoses which included dementia, anxiety, heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), insomnia, and macular degeneration (an eye disease that causes vision loss). In addition, R1's MDS identified she required substantial to maximum assistance with ADLs, was frequently incontinent of bowel and bladder, and was at risk for pressure ulcers. According to R1's MDS she had no rejections of care. R1's care plan dated 3/9/25, identified R1 had an ADL self-care performance deficit related to dementia. Interventions included I like my nails trimmed and cleaned during my bath, preferred bathing twice a week in the afternoon. R1's care plan dated 4/22/25, identified R1 was at risk for bladder incontinence and required staff assistance. Interventions included to offer toileting four times a day - upon rising, after brunch, before supper and before bed. R1's bath report for May and June 2025, did not identify if nail care was offered, refused or completed. On 6/9/25 at 6:12 p.m., R1's fingernails were noted to be long, polished and had a dark brown caked substance under them. On 6/11/25 during a continuous observation that began at 8:16 a.m., R1 was observed seated in the dining room eating hot cereal, she had a nutritional drink, was dressed for the day, and had a newspaper on the table. -8:32 a.m. R1 remains at the table said breakfast was okay but not her favorite, would have rather had peanut butter toast. -8:51 a.m. R1 remains at the table in the dining room, no staff interactions -9:11 a.m. R1 remains at the table in the dining room, no staff interactions -9:30 a.m. table cleared R1 ate 100 % of breakfast -9:56 a.m. R1 remains at the table in the dining room, no staff interactions, no position change, no off-loading -10:37 a.m. R1 has remained seated at the table in the dining room, no repositioning, no position change, no offer of bathroom, no staff interactions -11:16 a.m. R1 has remained in the dining room at the same table no position change, no offer of bathroom, no staff interactions (now 3 hours seated in the same chair in the same spot) -11:22 a.m. R1 has been served her brunch meal -11:40 a.m., asked licensed practical nurse (LPN)-C about R1 sitting in the same spot since breakfast. LPN-C stated it was too long for anyone to sit in one position and she would find someone to do a position change. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-12:01 p.m., LPN-C asked two different nursing assistants for help to reposition R1 and both stated they were busy and unable to assist -12:19 p.m. activity staff were going to bring R1 directly to exercise class with out a bathroom break -12:21 p.m. R1 was brought to her room by NA-E and NA-F. Both donned isolation gowns, gloves, placed transfer belt on R1 and transferred her to the toilet. NA-E stated R1 was not always continent and said R1's brief was wet but not soaked. -12:36 p.m. R1 was was transferred back to the wheel chair, brought to her bed, transferred to her bed for skin check. Skin was slightly red with no open areas. R1 was transferred back to her wheel chair. -12:43 p.m., NA-E looked at R1's nails and said oh ya, her nails look dirty, NA-E stated she was going to try to soak her hands and clean her nails later. On 6/12/25 at 12:30 p.m., R1 was brought from the dining room directly to the exercise program in [NAME] Park. No stop was made in R1's room for toileting. On 6/11/25 at 12:26 p.m., NA-E stated R1 was not on a toileting schedule. NA-E and NA-F said they were taking care of 30 residents. During the chair to toilet transfer and chair to bed transfer NA-F said can we do this later, said they had no time to wait around. On 6/11/25 at 2:13 p.m., LPN-C stated it had been too long for R1 to sit without a position change. Said she had never seen R1 move or change her position once she was in her wheel chair. LPN-C said they did not have enough staff today. Verified the NAs were taking care of 30 residents, she was passing medications for 25 residents, they were expecting two new residents and one resident was coming back to the facility. LPN-C stated she worked days and would not pick up night shifts because she didn't want to be the only licensed staff in the building. On 6/12/25 at 7:55 a.m., RN-E verified resident nails should have been looked at daily when they were being dressed. RN-E sated there was not enough staff on the unit, staff are running and triaging their work. RN-E verified sitting for over three hours in one place is too long and she would expect a resident to be offered every two hour toileting. RN-E stated R1 was on a toileting schedule and not being left sitting in one spot for over three hours might be related to staffing (lack of). During an interview on 6/12/25 at 12:40 p.m., NA-D stated R1 was supposed to be toileted after brunch, but doesn't always happen because sometimes working alone. On 6/12/25 at 3:00 p.m. the DON verified R1 sat too long without being offered a position change or toileting. The DON stated nail care should have been done on bath days. The policy Nails care of (finger and toe) dated 9/2006, identified the purpose of nail care was to provide cleanliness, prevent the spread of infection, for comfort, and to prevent skin problems. The policy did not address the frequency of nail care. The policy Urinary Incontinence Program dated 4/6/15, identified the purpose as follows: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Each resident who is incontinent will be identified, assessed, and provided appropriate care and services to achieve or maintain their greatest level of continence. Each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible. R64: R64's significant change MDS dated [DATE], identified R64 had diagnoses which included dysphagia (difficulty swallowing foods or liquids arising from the throat or esophagus) following cerebral infarction, vascular Parkinsonism (a form of parkinson's caused by damage to blood vessels in the brain, often due to stroke or other vascular issues), rheumatoid arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet), anxiety, and adult failure to thrive. In addition, R64's MDS identified she was dependent on staff for ADLs, was always incontinent of bowel, was at risk for pressure ulcers, and had no rejections of care. A complaint was received on 3/24/25, with concerns R64 was left soiled and wet on 3/19/25, 3/20/25, from end of day shift through evening and night shift until day shift on the following day. During an interview on 6/9/25 at 6:17 p.m., NA- O stated she was working in [NAME] Woodland /[NAME] and was taking care of 28 residents. NA-O was working with two other NAs who would be leaving at 6:30 p.m., so after dinner they got almost everyone on the unit to bed because the other two would be leaving soon. Still had four residents to settle for the night. During an interview on 6/10/25 at 1:44 p.m., NA-J stated they had put their initials on R64's brief at the end of their shift for three days. They stated their initials were on the brief when they returned for their next day shift and said the brief had not been changed by evenings or nights. R64 had been a resident on the [NAME] Woodland / [NAME] unit. NA-J stated they reported this to two different nurses, the nurse manager, and the DON. NA-J stated the past weekend there were only two NAs working, could not complete check and changes and could not get a shower done for R40. NA-J stated feels like every day it's short staffed, can't get residents up by 10:30 a.m., can't get daily weights done, no time for one to ones with residents, do what you can. Said there should be three NAs for [NAME] Woodland / [NAME], but there isn't always. During an interview on 6/12/25 at 8:20 a.m., RN-D stated she had no knowledge of any NA coming to her with concerns that R64's brief was not being changed. During an interview on 6/12/25 at 9:01 a.m., NA-I stated he recalled helping a co-worker with a brief change for R64 and saw twice that the brief had NA-J's initials on it from the day before. NA-I stated he recalled NA-J had reported the concern to management. NA-I stated could not recall any education on check and changes after the reported incident. NA-I stated when they were the only NA couldn't get checks and changes done timely. NA-I stated evening shift was the shift where there typically wasn't enough help, often leaving the unit(s) short from 6:30 p.m.-10:30 p.m., when trying to get residents ready for bed. Said the facility can only mandate NAs for four hours when there is a call in so then work short for the rest of the shift. During an interview on 6/12/25 at 12:40 p.m., NA-D stated she recalled changing R64 with another NA and saw the NA's initials from the day before on the resident's brief. NA-D said R64's brief would often be soaked in the morning. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/12/25 at 2:09 p.m., the DON brought in a nursing note for R64 dated 3/21/25, 11:13 a.m., Peri area/buttocks checked today for concerns. ADON and NAR present. No redness, irritation or open areas noted to groin/vaginal or buttock areas. Coccyx has a dry/flaky area on it. Calmoseptine applied to coccyx. Catheter patent and draining amber colored urine. The ADON was not available for interview, no longer worked at the facility. The DON stated nothing was wrong and they did not complete an investigation. She recalled she was not working on that day. The DON stated it would be her expectation that R64 would have been checked and changed every two hours and repositioned to prevent skin breakdown. R9: R9's admission MDS dated [DATE], indicated cognitive patterns weren't assessed. R9's MDS included diagnoses of pneumonitis due to inhalation of food and vomit, acute cystitis, orthopedic aftercare, chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypoxia, heart failure, and dementia. R9 had limited range of motion in both upper extremities, one lower extremity, needed assistance with ADLs, and had an indwelling catheter. R9's Order Summary Report dated 6/12/25, didn't contain a line item for indwelling catheter care. R9's care plan dated 5/22/25, didn't address ADL status, catheter care, medications, or treatments. During an interview on 6/9/25 at 6:44 p.m., R9 stated she didn't get washed up in the morning and would like the opportunity to wash her face and stuff. During an interview on 6/11/25 at 10:46 a.m., R9 was up in her wheelchair with the over-the-bed table in front of her. R9 stated the aids helped her up to her chair and got her some breakfast, but she didn't get washed up. During an interview on 6/11/25 at 1:19 p.m., AS-G stated they would normally get their work done on the [NAME] Park unit, but not on the [NAME] unit. AS-G reported some of the things they couldn't get done were restorative care, charting, and things like that but that they could get showers and ADLs done most of the time. AS-G stated they were constantly on their feet, keeping up with call lights, running around and doing the best they could. For R9, AS-G stated they got her up right before brunch and they were not able to do her cares. During an interview on 6/11/25 at 1:37 p.m., AS-H stated they were able to get their work done but not to the ability they would like; they have so many call lights and the staffing was usually only two staff on this unit. AS-H stated there were about 10 two-person transfers in this unit so when they went into a room to help a resident, the floor was left empty. AS-H stated they could get everyone up and dressed but would like to be able to give a nice bed bath and spend more than 10 minutes with them and get to really get to know them. For R9 today, she got up later than usual, and AS-B wasn't able to do any washing up for her today, just able to get her dressed, empty her catheter and transfer her to a chair. AS-B confirmed this meant catheter care wasn't done. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/12/25 at 8:43 a.m., RN-D stated care plans were done 14 days after admit and R9's assessment reference date (ARD) was 5/22. RN-D didn't comment about R9's incomplete care plan, but did say care plans were important, so aids and nurses knew how to care for the resident. RN-D stated they should be doing catheter cares at least twice a day, anytime incontinent, and this included peri care and cleaning the tubing where it exited the body. This was important to prevent infection. During an interview on 6/12/25 at 9:34 a.m., the DON stated it was their protocol to have a comprehensive care plan in place 14 days after the ARD, or 21 days after admission. The DON stated catheter care was part of AM and PM cares, and the risk of not doing it could be a urinary tract infection (UTI). A policy, Catheter Care dated 9/11/23, identified the purpose was to maintain catheter patency, prevent infection and ensure dignity and provided instructions for care, but didn't address frequency. The daily care procedure was described: Gather all equipment: basin with warm water and soap, towel and washcloth, disposable gloves and other personal protective equipment as necessary, collection device, and antiseptic ointment as ordered, if applicable. Wash your hands thoroughly before and after performing the procedure; immediately after your hands encounter blood, body fluids, or tissues, and/or after handling soiled laundry or linen. Gloves must be worn while giving catheter care. Gowns will only be necessary if soiling of your clothing with urine, feces, or blood is likely. Masks/eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. Keep soiled linen from touching your clothing. Knock before entering the room, introduce yourself, and inform the resident of the procedure. Place the equipment and supplies on the bedside stand or over the bedside table and arrange the supplies so that they can be easily reached. Position resident in semi-Fowlers position, if tolerated. Put on gloves. For female, separate labia. For male, push back foreskin. Wash perineum with soap and water, taking care to wash from front to back; using one area of washcloth per washing stroke; rinse and pat dry using same procedure. Cleanse area of catheter insertion site using soap and water being careful not to pull on catheter or advance further into urethra. Hold catheter at insertion site to anchor, wash downward from meatus four inches, changing washcloth with each stroke; rinse and pat dry using same procedure. Towel dry perineal area and on the male return the foreskin to normal position. Secure catheter by utilizing a leg band. Position resident for comfort and remove and clean used equipment. Make sure catheter tubing and drainage bag are kept off the floor. Place it in a basin if it cannot hung from the bed. Cover drainage bag with a cloth/vinyl bag to protect the dignity of the resident. Remove and discard gloves. Wash hands. R16 R16's quarterly MDS dated [DATE], identified intact cognition and diagnoses of hemiplegia and hemiparesis affecting left side, cerebral infarct (stroke), dysphagia (difficulty swallowing), traumatic subarachnoid hemorrhage (brain bleed), and post-traumatic seizures. R16 needed maximum assistance with personal hygiene and dressing upper and lower body, and was dependent for transfers. R16's provider orders dated 3/27/25, identified vital signs, weight, and skin checks were to be done weekly on bath/shower day every Monday. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R16's care plan dated 3/24/25, identified a self-care deficit with interventions to provide an assist of one for oral and personal hygiene, and to shave face upon request. R16's progress notes didn't contain an entry for resident refusal of bath/shower, and didn't contain a skin check for Monday 6/9/25. During an observation and interview on 6/9/25 at 2:28 p.m., R16 was noted to have chin hair approximately ¼ to 1/3 inch long. R16 stated they were going to shave her when she had her bath, but they were short staffed and she didn't get her bath and that was when they usually shaved her. During an observation on 6/10/25 at 8:53 a.m., R16 was noted to have chin hairs as she did yesterday. During an observation on 6/11/25 at 8:32 a.m., R16 was in bed eating toast and was noted to have chin hairs still present. During an interview on 6/12/25 at 1:04 p.m., LPN-E stated she had noticed the facial hair on R16 and had asked NA-I to shave her on maybe Tuesday, but it must not have gotten done. During an interview on 6/12/25 at 1:26 p.m., the DON stated R16 often refused different things, and they had been adequately staffed on her bath day. The DON would expect a note with refusals and if a resident refuses often, she would expect it to be in their care plan. Resident Rights: see also F550 R218's admission MDS dated [DATE], identified R218 had diagnoses which included heart disease, hypertension, and hyperlipidemia, no concerns with swallowing or oral/dental concerns. In addition, R218's MDS identified she was moderately cognitively intact. R218's care plan dated 3/21/25, identified R218 had a potential for alteration in nutrition due to leaving 25 % or more food uneaten at meals. Interventions included to monitor food and fluid intake, to offer fluids and snacks. On 6/9/25 at 3:39 p.m., R25 said there was sometimes not enough food during a meal. On 6/9/25 at 4:19 p.m., R218 said didn't always like the choices for food. On 6/11/25 at 11:00 a.m., in the [NAME] Woodlyn and [NAME] dining room R38 asked a staff member for more and pointed to a black bowl. R38 was told I don't think we have any more of that. The staff person did not go to the kitchen window and inquire if there was more watermelon. On 6/11/25 at 11:02 a.m., R38 verified she was told by staff there wasn't any more watermelon and said it was good. On 6/11/25 at 11:13 a.m., NA-C stated she didn't' really know if they were out of watermelon and stated residents get one serving each at a meal. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/11/25 at 11:40 a.m., LPN-C stated residents could have seconds as long as it was okay with their diet. On 6/11/25 at 12:08 p.m., dietary aide (DA)-A stated they did not run out of watermelon at brunch, added residents can have seconds and there was plenty of watermelon in the kitchen if staff would have asked. On 6/12/25 at 8:16 a.m., RN-D stated residents should get seconds unless they have a dietary restriction. RN-D stated possibly the failure to see if there was more watermelon could have been related to staffing as staff are always rushing to the next thing they have to do. The facility policy titled Dining - Atmosphere undated, identified residents should be treated with dignity and respect, included it was extremely important to offer as many choices as possible when it came to meal time, including what to eat. In addition, the policy identified the dietary manager would routinely perform meal rounds to determine if the meals were attractive and nutritious and met the needs of the residents. The dietary manager would observe meals for preferences, portion sizes, and would report any concerns to the director of nursing or administrator. Resident Medication Administration: see also F554 R40: R40's admission MDS dated [DATE], identified R40 had diagnoses which included chronic obstructive pulmonary disease (COPD [a group of lung disease that block airflow and make it difficult to breathe]), mild cognitive impairment, and supraventricular tachycardia (SVT [a faster than normal heart rate beginning above the heart's two lower chambers]). In addition, R40 required partial to moderate assistance with activities of daily living. R40 had no rejections of care. R40's Order Summary Report current as of 6/12/25, identified R40 had orders for ipratropium-albuterol (used to treat COPD by opening the airways and reducing inflammation) inhalation solution 0.5-2.5 (3) milligrams per 3 milliliters one vial inhale orally three times a day dated 6/10/25. Instructions included to assess respiratory status, oxygen saturation, pulse and lung sounds after the treatment. R40's care plan dated 4/7/25, identified R40 was not able to administer her own medications. Interventions included, need to supervise medication per order. On 6/10/25 at 10:16 a.m., during a continuous observation, LPN-D set up a nebulizer treatment for R40 and said, all right I'll see you in a little bit and then left the room. -at 10:24 a.m., R40 was holding the nebulizer set up with the mouth piece in her mouth, the treatment sounded done, no staff returned to check on her. -10:28 a.m., R40 continued to hold the nebulizer set up with the mouth piece in her mouth, the treatment sounded done, no staff returned to check on her. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-10:30 a.m., R40 held the nebulizer set up in her hand no longer in her mouth, no staff returned to check on her. -10:33 a.m., R40 had put the nebulizer set up with the mouth piece back into her mouth, no staff had returned to check on her. -10:37 a.m., no staff had returned to the room R40 continued to hold the nebulizer treatment with the mouth piece in her mouth. -10:45 a.m., no staff had returned to the room R40 continued to hold the nebulizer treatment with the mouth piece in her mouth. -10:50 a.m., 34 minutes after the nebulizer treatment had been started the nurse was alerted that R40 was still holding the nebulizer set up with the mouth piece in her mouth. LPN-D returned to the room, stopped the nebulizer treatment, took the nebulizer set up into the bathroom and rinsed the nebulizer set up. LPN-D did not listen to R40's lungs, check her heart rate or an oxygen saturation. On 6/9/25 at 2:37 p.m., FM-A, B, C stated staff were not staying with R40 during her nebulizer treatments. They thought this was because there was not enough staff. On 6/10/25, at 2:10 p.m., LPN-D verified she left R40 until she was alerted that R40 was still holding the nebulizer treatment. LPN-D verified she did not return during the treatment to check on R40 and did not check, R40's heart rate, oxygen saturation, or listen to R40's lung sounds. LPN-D stated, just too busy, stated she set up the treatment and went on to pass more medications and did not return until alerted. LPN-D reviewed R40's record and verified she was not assessed for self-administration of medications. On 6/12/25 at 8:31 a.m., RN-D stated if a resident had been assessed to be okay to self-administer medications it would be okay to start a nebulizer treatment and come back in 15 minutes, check vital signs, listen to lung sounds, rinse the equipment. RN-D verified if a resident had not been assessed to self-administer medications, it would not have been okay to leave the resident alone during the nebulizer treatment. RN-D stated that portion of the hallway was split with another resident unit and the residents in the split hall don't get as much attention. On 6/12/25 at 11:15 a.m., FM-B handed over several pages of notes that included concerns about staffing (lack of). Note dated 6/3/25, second time in three days that I found neb hooked up, used, laying on the overbed table. I cleaned it. No one ever came in to check it in the three plus hours I was there. Facility Assessment: A review of the Facility assessment dated [DATE], identified the facility mission statement as Expressing Christ love by providing care that values every human life. The average daily census for the past 12 months was documented as 63. The unit staff analysis for [NAME] Woodland and [NAME] was number of active beds 31. Nursing assistant hours in 24 hour plan was 2.88 hours per resident. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A grid provided by the facility in the initial facility assessment dated [DATE], identified staffing for the facility as follows: licensed staff providing direct care on days, evenings and nights was three (weekend staffing was the same) nursing assistant / trained medication aides on days, evenings was listed as six and nights was listed as three (weekend staffing was the same). The Daily Nursing Schedules identify the following staffing for [NAME] Woodland / [NAME]: Days 6:30 a.m. - 3:00 p.m. one licensed nurse = one 6:30 a.m. - 2:30 p.m. two nursing assistants and 6:00 a.m. - 2:00 p.m. one nursing assistant = three Evenings 2:30 p.m. - 11:00 p.m. one licensed nurse 2:30 p.m. - 10:30 p.m. three nursing assistants Nights 10:30 p.m. - 7:00 a.m. one licensed nurse 10:30 p.m. - 6:30 a.m. one nursing assistant A review of staff working on [NAME] Woodland and [NAME] for the following days revealed the following staffing: 5/28/25, Days one licensed staff, one NA for eight hours and one NA for six hours (short by 10 hours) Evenings one licensed staff, three NAs Nights no licensed staff, one NA (short 8 hours of licensed staff) 5/29/25, census 66 Days one licensed staff, two NAs for eight hours and one NA for 1.5 hours and one NA for four hours (short 2.5 hours) Evenings one licensed staff and one NA for eight hours and one for seven hours (short by one hour) Nights one licensed staff and one NA. 6/6/25, census 65 Days one licensed staff, two NAs (short eight hours) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Evenings one licensed staff and two NAs (short eight hours) Nights one licensed staff and one NA 6/7/25, census 65 Days one licensed staff, two NAs for eight hours and one NA for four hours (short four hours) Evenings one licensed staff and two NAs for eight hours and one for four hours (short four hours) Nights one licensed staff and one NA 6/8/25, census 65 Days one licensed staff, two NAs (short eight hours) Evenings one [NAME][TRUNCATED]

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure competent, trained staff operated tube feeding pumps and managed tubing for 1 of 1 resident (R41) reviewed for tube feeding. Findings include: R41's quarterly Minimum Data Set (MDS) dated [DATE], indicated R41 was moderately cognitively impaired with the diagnoses of stroke, dysphagia, generalized muscle weakness, and epilepsy. MDS Section GG indicated R41 was dependent for activities of daily living and transfers. MDS Section K. Percent Intake by Artificial Route indicated R41 received 51% or more of nutrition through parenteral or tube feeding. R41's care plan last revised 6/3/25, indicated R41 required tube feeding related to dysphasia and directed staff to use infection control precautions and related techniques following the manufacturer's recommendations when stopping, starting, flushing, and giving medications through the feeding tube. R41's Order Summary Report Active orders as of 6/12/25 included the following orders: -NPO diet -Enteral Feed Order six times a day continuous feeding: flush my tubing 6x/day with 150 ml [milliliters] of tap water. -Isosure 1.5 calorie oral liquid continuous feeding at 50 ML an hour. During an observation on 6/11/25 at 9:12 a.m., NA-A and NA-B donned personnel protective equipment PPE and entered R41's room to get R41 up for the day. -9:20 a.m., NA-A placed R21's tube feeding on hold and disconnected the tubing from R41 and hung it over the top of the pole without capping the end and then NA-A and NA-B proceeded with cares, and transfer to and from the bathroom and back to R41's chair. -9:28 a.m., NA-A took R41's tube feeding pump in hand and explained they were transferring it to R41's wheelchair pole. While maneuvering the pump the tubing and the uncapped connection end of the tube feeding tubing was noted to be on the floor. When pointed out to NA-A, NA-A picked the tubing off the floor and wiped it with a tissue, connected the tubing to R41 and then proceeded to restart R41's pump. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 9:39 a.m., NA-A stated when a resident had a tube feeding, they normally stopped and disconnected the tube feeding when they were taking the resident to the bathroom or transferring the resident in and out of bed. NA-A stated they had not had a class on tube feeding management or operating the tube feeding pump, nurses had shown them how to pause the pump. NA-A stated they did whatever they could to prevent infection and explained they weren't sure what to do when they saw the tubing on the floor, they had wiped the end of R41's tube feeding tube with a tissue to help prevent infection. R41 questioned if they should have wiped it with an alcohol wipe instead, said they hadn't been sure what to do and indicated they would be talking to the nurse. After interview, NA-A donned PPE and disconnected R41's tube feeding. On 6/11/25 at 9:52 a.m., NA-A reported they had stopped R41's tube feeding, talked to the nurse, and the nurse was going to replace R41's tubing. During an observation on 6/11/25 at 10:02 a.m., licensed practical nurse (LPN-B) replaced R41's tubing. During an interview on 6/11/25 at 11:26 a.m., LPN-B stated NAs were not trained to do anything but put the tube feeding pump on hold. The NA should be getting a licensed staff to stop, start or connect/disconnect a tube feeding. During an interview on 6/11/25 at 3:18 p.m., NA-N stated tube feeding pumps were strictly a nurse thing. NAs did not do anything with the pumps or connections to the resident. During an interview on 6/12/25 11:31 a.m., NA-M stated as an NA they did not disconnect/connect or touch the pump settings for tube feedings. Those were strictly nurse responsibilities. During an interview on an 6/12/25 at 11:52 a.m., registered nurse (RN-A) stated NAs should not be disconnecting or connecting a resident's tube feeding, nor should NAs stop or start the tube feeding pump. Only licensed staff should be doing those tasks. NAs are not trained to do anything with the pumps or tube feedings other than manage the position of the tube when providing cares so it does not get caught on anything. It is expected that a NA would get a licensed staff to carry out those activities. During an interview on 6/12/25 at 12:59 p.m., the director of nursing (DON) stated the facility did not train NAs to operate tube feeding pumps or to disconnect/connect tube feeding tubing. NAs are not to touch the tube feeding pump or connection to the resident. Only licenses staff may operate the pump and or connect/disconnect tube feeding tubing from the resident. The DON indicated they expected NAs to seek licenses staff for tube feeding pump management and tubing connection/disconnection. Tube feeding management and pump operating education was requested for NAs. The DON confirmed the facility did not provide/have record of this education. The facility policy Enteral Feeding Tube Usage dated 4/1/19, identified the purpose of the policy was to provide guidance to licensed staff and directed all licensed staff would be trained and observed for competency in enteral feeding tube care and services. The policy did not include NAs as approved for tube feeding tube management or pump operation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation interview and record review the facility failed to ensure medications and biologics stored in the medication room were safely secured to prevent resident access and diversion. In addition, the facility failed to ensure safe refrigeration temperatures were maintained for medications requiring refrigeration. These unsafe practices had the potential to impact residents who received medication from the 200s/300s medication fridge and or could gain access to the mediation room. Findings include: A review of the medication room located at the intersection of the 200 and 300s hallways was completed on 6/11/25 at 3:39 p.m., with RN-B and RN-C. Some storage cupboards had locks but were not locked, and some cupboards did not have locks. Stock meds were stored in a lockable cupboard that was not locked. Three bins of medications were stored in a lower cupboard without a lock. The cupboard was labeled medications for destruction. The medication fridge was locked. RN-B unlocked the fridge and confirmed the fridge internal temperature was 48 degrees Fahrenheit. RN-B stated 48 degrees was out of safe storage parameters and indicated they would have to notify maintenance. The fridge contained immunizations, GLP-1 injectables, insulin and controlled medications. The temperature log on the front of the fridge had incomplete documentation. The last recorded temperature was 46 degrees Fahrenheit on 6/10/25. During a follow-up interview on 6/11/25 at 4:10 p.m., RN-B stated they had put in a work order and notified the director of nursing (DON) the fridge was out of temperature range. During an interview on 6/11/25 at 4:16 p.m., the DON stated 48 degrees was out of the safe medication storage range for insulins and immunizations and indicated the medications would likely have to be destroyed. They intended to contact the consulting pharmacist for advisement on final disposition of the medications in the fridge. During a follow-up on 6/12/25 at 7:23 a.m., the DON unlocked the medication fridge and confirmed the internal fridge temperature reading was 48 degrees Fahrenheit. The DON instructed unit staff not to use any medications from the medication fridge and stated they were waiting for a return call from the consulting pharmacist. On 6/12/25 at 8:47 a.m., the DON reported the consulting pharmacist had recommended the following medications from the unit fridge temping at 48 degrees Fahrenheit be destroyed and replaced by the facility: ---five lantus Solostar pens ---four Mountjaro prefilled Pens 7.5mg/0.5ml ---four Mounjaro prefilled Pens 2.5mg/0.5ml ---one dose Prevnar injection (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	---one dose Shingrix injection ---one dose Abrysvo powder injection. During an interview on 6/12/25 at 2:04 p.m., registered nurse consultant (RNC-C) confirmed on 6/11/25, they had witnessed the 200s/300s medication room being exited by staff and left open and unattended. RNC-C stated medication rooms should be locked when unattended by a licensed staff for the safety of residents and to prevent diversion. The DON was present and expressed agreement with RNC-C and indicated it was the expectation medication rooms remained locked per policy. The DON reported because the refrigerator was temping at 48 degrees Fahrenheit medications from that fridge had been destroyed. No residents at the facility had received medications from that fridge once the temperature was found to be 48 degrees. The refrigeration logs utilized by the facility had two spots each day to record fridge temperatures. The facility provided monthly Refrigeration Temp Logs for 3/2025 through 6/10/25, for the 200s/300s medication fridge. The logs showed 36 missed temperature entries in March, 31 missed entries in April, 37 missed entries in May, and the June log showed 3 missed entries as of 6/10/25. The facility policy Medication Storage Policy dated 7/27/16, included the following: ---Line item 7: compartments: including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes containing drugs and biologicals shall be locked when not in use. ---Line item 9: medication refrigerator temperatures are to be kept between 36 to 46 degrees Fahrenheit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure food and beverages were monitored for safe food temperatures. This had the potential to effect all residents in the facility. Findings include: During observation on 6/11/25 at 10:37 a.m., residents observed sitting in the dining room waiting for brunch meal. Beverage cart positioned by serving area of kitchenette and contained these items in a plastic tub: apple juice carton, cranberry juice carton, orange juice carton, ice water pitcher, milk in half gallon plastic carton. Tub did not contain any ice cubes or cooling device. All residents on units [NAME] Woodland and [NAME] were served beverages from this cart. On 6/11/25 at 11:28 a.m., dietary aide (DA)-A prepared to take beverage cart back to kitchen. DA-A prompted to pour a glass of milk and to check the temperature. DA-A retrieved thermometer from kitchenette, and poured a glass of milk. Milk measured to be 44.5 degrees Fahrenheit (F). DA-A stated the milk was above the guidelines for serving cold beverages and should be thrown away. DA-A then disposed of remaining milk from the beverage cart. During observation on 6/12/25 starting at 10:32 a.m., beverage cart positioned by serving area of kitchenette and contained these items in a plastic tub: apple juice carton, cranberry juice carton, orange juice carton, ice water pitcher, milk in half gallon plastic carton. Tub did not contain any ice cubes or cooling device. On 6/12/25 at 11:20 a.m., dietary aide (DA)-A prepared to take beverage cart back to kitchen. DA-A prompted to pour a glass of milk and to check the temperature. DA-A retrieved thermometer from kitchenette, and poured a glass of milk. Milk measured to be 41.5 degrees Fahrenheit (F). DA-A stated the milk was above the guidelines for serving cold beverages and should be thrown away. DA-A then disposed of remaining milk from the beverage cart. During interview on 6/12/25 at 3:20 p.m., director of nursing (DON) stated expectation for food and beverages to be served at the proper temperatures. DON stated serving food and beverages at unsafe temperatures could lead to food-borne illness. Food Temperature policy undated, indicated all cold food items must be served at a temperature of 40°F or below. Policy also indicated temperatures should be taken periodically to ensure cold food stays below 40 degrees Fahrenheit during the portioning, transporting, and serving process until received by the resident. The United States Food and Drug Administration (FDA) Food Code dated 2022, identified milk as a 'temperature control for safety' food and foods requiring refrigeration should be maintained at or below 41 degrees F to prevent food-borne illness. Temperature logs for fridges, freezers, and meals requested but not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure cleaning and sanitization of surfaces for 1 of 1 resident (R59) reviewed for infection control. In addition, the facility failed to ensure proper handling of laundry to avoid contamination in the laundry area, and failed to have an active water management program. These deficient practices had the potential to impact all residents residing at the facility. R59: R59's re-entry Minimum Data Set (MDS) dated [DATE], indicated R59 was cognitively intact with the diagnoses of chronic kidney disease, resistance to vancomycin, and congestive heart failure. During a continuous observation on 6/10/25, at 9:01 a.m., licensed practical nurse (LPN-A) parked their cart outside of R59's room, donned PPE and entered R59's room. Signs on the door indicated R59 was in isolation with droplet precautions. LPN-A exited R59's room with a nasal swab, put swab in tube, discarded swab and put specimen tube in tray holder on the middle of the medication cart work area. LPN-A removed PPE and sanitized hands and parked the medication cart in front of the nurse station with the specimen on the cart. LPN-A assisted a resident to the dining table. Returned to the medication cart, sanitized hands, moved the specimen sample to a pull-out extension on the medication cart and proceeded to pull 3 medication bottles from the medication cart setting them on the center of the medication cart where the specimen had been. During an interview on 6/10/25 at 9:05 a.m., LPN-A confirmed they had taken a nasal swab from R59 and had put the specimen tube and tray on their medication cart. LPN-A stated they had sanitized their hands before they moved the specimen to the side of their medication cart but was not clear if they had sanitized their hands before touching the pill bottles. LPN-A confirmed they had not sanitized the surface of their medication cart prior to setting another resident's pill bottles on the surface. LPN-A moved the pill bottles and sanitized the top of the cart mid interview and indicated they were sanitizing the surface for infection control. The specimen was still on LPN-A's medication cart at the end of the continuous observation at 9:23 a.m During an interview on 6/12/25 at 2:27 p.m., the infection prevention registered nurse (RN-F) stated the medication cart was not the best place to set collected specimens, it would be best practice to place COVID tests or other collected specimens in an area away from resident care areas. The medication cart surfaces should have been properly sanitized before other residents' mediations were set on the surface. This is important to prevent contamination and for infection prevention. The DON was present during the interview and expressed agreement with RN-F. Laundry (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation and interview on 6/12/25 at 7:20 a.m., laundry personnel (LP)-A was walking down the front hall with a rolling bin of dirty linen and personal laundry in bags, the bin was not covered. LP-A was wearing gloves, kept the same gloves on after collecting dirty linen from the tub room, then went into the Home Acres unit and collected dirty linen there, placed it in the bin and rolled over to the clean laundry door and opened the door with the same gloved hands. LP-A rolled the dirty linen through the clean side of the laundry area and loaded the washing machine by ripping open the bags and placing the clothes and linens together inside. LP-A stated they brought the dirty bins through the clean side, but when the nursing assistants (NA)s brought in dirty clothes and linen they went into the dirty side and just dropped off the bags into bins. LP-A stated they didn't have face shields or gowns for handling the dirty laundry, but they could go out to one of the units and get one or that a lot of times there were some clean ones in the dryer, and they could use those. LP-A also provided the mop heads and rags got washed separately, and they did them last and let them set overnight and then put in the dryer the next morning. During an interview on 6/12/25 at 7:50 a.m., registered nurse consultant (RNC) stated it would be the expectation for dirty laundry to be brought through the dirty side of the laundry area, and for staff to use personal protective equipment when needed. A policy, Linen Handling dated 9/1/23, defined its purpose was to provide guidelines for staff handling linens. The policy defined linen as non-disposable personal clothing, towels, washcloths, tablecloths, sheets and other bedding and any garments worn or used in the care center. The risk of environmental contamination may be reduced by having employees bag or contain contaminated linen at the point of use, and not sorting or pre-rinsing in resident care areas. The following process will be necessary when performing this procedure: -Personal protective equipment will be worn (e.g. gowns, gloves, mask, etc.) per the standard. -Do not allow linen, clean or soiled, to touch clothing or uniform. -Handle all soiled linen as though it is potentially infectious. -Remove gloves and wash and dry hands thoroughly after contact with soiled linen. -All soiled linen or clothing will be rinsed out in a hopper in the soiled utility room. -Gloves, gowns and face masks will be available for use when rinsing out soiled linen. -Employees sorting or washing linens must wear a gown/apron, gloves, and a mask (as needed if aerosolization occurs). -Wear heavy-duty gloves when handling and sorting soiled linen. Always wash hands after completing the task and removing gloves. -Keep soiled and clean linen, in their respective hampers and laundry carts, and separate at all times. Water Management (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observations 6/11 and 6/12/25 it was noted facility had two water features, one a fishpond in the center of the 400's unit and one small fountain in the 100s unit. During an interview on 6/12/25 at 3:15 p.m., maintenance worker (MW)-B explained the Legionella Prevention Monitoring Record for January to June 2025 and identified the question marks for the row titled Ice Maker Scaling/Cleaning had question marks for April weeks one, three and four because he didn't know if the other MW had done it when he put this together. For the row titled no fish water feature, where no was entered in every week, every month since the second week of January, MW-B stated the non-fish water feature had been off for a while, but he had turned it on back in January and did put chlorine tabs in it once a month. During an interview on 6/12/25 at 4:30 p.m., maintenance worker (MW)-B stated they weren't doing any kind of water testing for their water features and didn't get water testing information from the City of Hibbing regarding their chlorination or pH levels. MW-B stated the map provided was the only water map they had. Review of facility-provided map of the building designating the water main shut-off, but no diagram of hot and cold-water flow from entrance throughout the building, and no identification of mixing or shut-off valves. A policy, Water Management Program (WMP) Legionella Prevention dated 2/27/24, identified its purpose was to provide direction to staff to prevent, identify and manage hazardous conditions that inhibit the growth of and spread of Legionella and identified the environmental services department was responsible for the program. The WMP would map the water system using text or flow diagrams indicating where cold water enters, was distributed including resident rooms, water features, ice machines, faucet fixtures and shower heads. Where cold water was heated and to what temperature including hot water heaters that served resident rooms, laundry, dietary and public restrooms. Where mixing valves were sued to temper water. Where hot water was distributed. pH balance was maintained through use of disinfectants are most effective within a narrow range of 6.5 to 8.5 pH. Scale and sediment deplete disinfectants and harbor a protective environment for Legionella and other germs.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure there was an active antibiotic stewardship program and that antibiotic time-outs were performed for 3 of 5 residents (R28, R48, R218) reviewed for antibiotic use. Findings include: R28: R28's quarterly Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition and diagnoses of Alzheimer's dementia and depression. R28's medical record reflected she was tested for COVID after developing respiratory symptoms on 5/23/25, and that result was negative. The facility then obtained orders for a respiratory panel for R28, which resulted negative for influenza, RSV, and COVID. R28's provider order dated 6/3/25, identified an order for azithromycin (a broad-spectrum antibiotic) 250 milligrams (mg) for five days for an upper respiratory infection. R28's medical record didn't contain an antibiotic time-out. R48: R48's quarterly MDS dated [DATE] identified moderately impaired cognition and diagnoses of urinary tract infection (UTI), chronic thromboembolic pulmonary hypertension, pulmonary fibrosis, heart failure, and low back pain. R48's medication administration record (MAR) for June 2025, identified an order for Macrobid (an antibiotic) 100 milligrams (mg) give one capsule by mouth two times per day related to other lower back pain until culture results, initiated 6/9 to 6/12/25. On 6/12/25, an order for Macrobid 100 mg give one capsule by mouth every morning and at bedtime for UTI for 3 days. R48's progress note dated 6/9/25 at 12:48 a.m., identified the urinary culture had no growth. On 6/10/25 at 9:48 p.m., a note identified R48 reported no signs or symptoms of UTI, and voiding clear yellow urine, temperature 97.2 degrees Fahrenheit (F). Tylenol given for lower back pain. R48's medical record didn't contain an antibiotic time-out. R218: R218's admission MDS dated [DATE] identified intact cognition and diagnoses of UTI, heart disease and diabetes mellitus. R218's MAR for June 2025, identified an order dated 6/2/25 for Levaquin 750 mg by mouth in the morning every other day for UTI until 6/8/25. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R218's medical record didn't contain an antibiotic time-out for the antibiotic ordered 6/2/25. During an interview on 6/11/25 at 3:06 p.m., registered nurse (RN)-F stated the facility used Health Connex (infection control software) to provide infection surveillance, including antibiotic tracking. RN-F stated the system was dependent on user-input to trigger an antibiotic time out, 48-72 hours after initiation, report. During an interview on 6/11/25 at 3:32 p.m., the director of nursing (DON) stated the facility used the McGreer's criteria for infections. The RN consultant (RNC)-C thought the McGreer's criteria was posted at the nurse's stations. Posted McGreer's criteria was only found on one nurse's station. RNC-C asked RN-E about McGreer's criteria and if it was posted, and RN-E stated she didn't know the facility had decided which criteria to follow and she hadn't seen anything around. During an interview on 6/12/25 at 8:23 a.m., RN-D stated for R218, the antibiotic was started in the hospital and the three days were passed prior to admission. R218 was re-admitted on [DATE]. RN-D was familiar with antibiotic time-outs, the infection prevention (IP) nurse would have been the one following that. RN-D stated time-outs were important to see the culture results to make sure the antibiotic was right, or it could create antibiotic resistance. During an interview on 6/12/25 at 2:36 p.m., licensed practical nurse (LPN)-C stated she was not familiar with McGreer's criteria, but she was familiar with the criteria for a urinary tract infection (UTI). During an interview on 6/12/25 at 3:03 p.m., the RNC confirmed she couldn't find the antibiotic time-outs for R28, R48, or R218. The RNC stated the expectation was that antibiotic time-outs were done 48-72 hours after initiation of the antibiotic. It was important to make sure the resident was getting the right antibiotic for the least amount of time. A policy, Antibiotic Stewardship Program dated 1/21/25, identified its purpose was to provide guidance to care center staff on the appropriate use of antibiotics. The guidance aims to preserve the effectiveness of antibiotic medications, reducing adverse side effects, limiting antibiotic resistance, and minimizing healthcare associated infection and includes: Care center will use McGeer's, Loeb's, or The National Healthcare and Safety Network (NHSN) criteria for assessing resident for infections, utilizing the Minnesota Antimicrobial Stewardship Program Toolkit for Long-term Care Facilities Appendix K: Infection Surveillance Definition Worksheet or electronic antibiotic tracking software. Direct care nurse and prescriber will conduct an antibiotic review process after an antibiotic is started, also known as antibiotic time-out for all antibiotics prescribed in the care center. When culture results are received, the nurse will contact the prescriber to review the results to ensure follow up on appropriate antibiotic therapy.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure residents were educated on and offered pneumococcal and influenza vaccinations upon admission for 1 of 5 residents (R38) admitted before 3/31/25 and failed to offer and educate on pneumococcal vaccinations for 1 of 5 residents (R59) who were reviewed for vaccinations. Findings include: R38's admission Record identified an admission date of 3/11/25, and diagnoses of and kidney failure, heart disease and urinary tract infection. R38's Immunization Audit Report dated 6/12/25, didn't identify any vaccination history. R59's admission Record identified an admission date of 4/25/25, and diagnoses of status post-kidney transplant, chronic kidney disease, and immunodeficiency. R59's Immunization Audit Report dated 6/12/25, didn't identify any vaccination history. During an interview on 6/11/25 at 3:06 p.m., registered nurse (RN)-F stated the facility did a vaccination reconciliation within 48 hours, it was part of the admit paperwork along with checking the Minnesota Immunization Information Connection (MIIC) for history. RN-F reviewed R38 and R59's record and confirmed there was no vaccine data. RN-F stated it was important to make sure you reconciled and offered vaccines so that they were covered as they were at increased risk. A policy, Resident Immunizations dated 1/21/25, identified its purpose was to provide direction to St. [NAME] Health Services of [NAME] (SFHS) employees regarding offering vaccinations. The Adult Immunization Schedule prepared by the Centers for Disease Control (CDC) to ensure residents are offered and encouraged to accept the appropriate vaccinations. The policy further indicated an immunization history would be taken upon admission including checking the MIIC system. Any immunizations that were not current or unknown vaccination histories would be shared with the attending physician and appropriate physician orders obtained. The resident's immunization history will be documented and maintained in the resident's electronic medical record (EMR).

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure residents were educated on and offered COVID-19 vaccinations upon admission for 2 of 5 residents (R38, R59) reviewed for vaccinations. Findings include: R38's admission Record identified an admission date of 3/11/25, and diagnoses of and kidney failure, heart disease and urinary tract infection. R38's Immunization Audit Report dated 6/12/25, didn't identify any vaccination history. R59's admission Record identified an admission date of 4/25/25, and diagnoses of status post-kidney transplant, chronic kidney disease, and immunodeficiency. R59's Immunization Audit Report dated 6/12/25, didn't identify any vaccination history. During an interview on 6/11/25 at 3:06 p.m., registered nurse (RN)-F stated the facility did a vaccination reconciliation within 48 hours, it was part of the admit paperwork along with checking the Minnesota Immunization Information Connection (MIIC) for history. RN-F reviewed R38 and R59's record and confirmed there was no vaccine data. RN-F stated it was important to make sure you reconciled and offered vaccines so that they were covered as they were at increased risk. A policy, Resident Immunizations dated 1/21/25, identified its purpose was to provide direction to St. [NAME] Health Services of [NAME] (SFHS) employees regarding offering vaccinations. The Adult Immunization Schedule prepared by the Centers for Disease Control (CDC) to ensure residents are offered and encouraged to accept the appropriate vaccinations. The policy further indicated an immunization history would be taken upon admission including checking the MIIC system. Any immunizations that were not current or unknown vaccination histories would be shared with the attending physician and appropriate physician orders obtained. The resident's immunization history will be documented and maintained in the resident's electronic medical record (EMR).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to ensure resident call lights were within reach from the bathroom floor in a resident bathroom for 1 of 2 residents (R17) and failed to ensure bathroom call light was in good repair for 1 of 2 residents (R27) reviewed for call light accessibility. Findings include: On 6/9/25 at 3:22 p.m., the bathroom call light for R17 was checked to see if it was in working order. The bathroom call light did not have a cord. On 6/10/25 at 1:30 p.m., the bathroom call light for R27 was checked to see if it was in working order and the cord was found to be frayed in the middle of the red cord, able to see white thread. On 6/11/25 at 1:55 p.m., maintenance (M)-A verified the call light in R27's bathroom was frayed and stated in needed to be replaced because it could break. M-A verified R17 had no call light cord in the bathroom. M-A verified it was a safety concern if a resident fell in the bathroom they would not be able to reach the button on the wall and call for help. During an interview on 6/11/25 at 3:47 p.m., the administrator stated every resident bathroom should have a call light with a cord for safety. The Call light policy dated 10/23/17, identified staff should remember to position the call light within resident's reach and to orient /re-educate the resident to the call lights in the room and in the bathroom. The policy did not address call light cords.